



Texas Department of Insurance

Division of Workers' Compensation

Medical Fee Dispute Resolution, MS-48

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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name

ANDREA SMITH, DC

Respondent Name

ARCH INSURANCE CO

MFDR Tracking Number

M4-15-0446-01

Carrier's Austin Representative

Box Number 19

MFDR Date Received

OCTOBER 1, 2014

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "We submitted a request for reconsideration to Sedgwick 07/28/2014, this request was in response to a \$949.76 no-pay of the \$949.76 for the FCE performed on 11/18/2013. Unfortunately our request was denied and we are seeking the balance owed to us."

Amount in Dispute: \$949.76

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: The respondent did not submit a response to this request for medical fee dispute resolution.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
November 18, 2013	CPT Code 97750-FC (16 units) Functional Capacity Evaluation (FCE)	\$949.76	\$869.60

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.204 and §134.203, effective March 1, 2008, sets the reimbursement guidelines for the disputed service.
3. 28 Texas Administrative Code §127.10, effective September 1, 2012 sets out the provisions for Designated Doctor Examinations.

4. The Division placed a copy of the Medical Fee Dispute Resolution request in the insurance carrier's Austin representative box, which was acknowledged received on October 9, 2014. Per 28 Texas Administrative Code §133.307(d)(1), "The response will be deemed timely if received by the division via mail service, personal delivery, or facsimile within 14 calendar days after the date the respondent received the copy of the requestor's dispute. If the division does not receive the response information within 14 calendar days of the dispute notification, then the division may base its decision on the available information." The insurance carrier did not submit any response for consideration in this dispute. Accordingly, this decision is based on the information available at the time of review.
5. The services in dispute were reduced/denied by the respondent with the following reason codes:
 - 947-R03-Upheld-No additional allowance has been recommended.
 - 5264-Payment is denied-service not authorized.
 - 197-Recommended allowance based on negotiated discount/rate.

Issues

1. Does a preauthorization issue exist in this dispute?
2. Does a contractual agreement issue exist in this dispute?
3. Is the requestor entitled to reimbursement for the FCE rendered on November 18, 2013?

Findings

1. According to the explanation of benefits, the respondent denied reimbursement for the disputed FCE based upon reason code "5264."

28 Texas Administrative Code §127.10(c) states in part "The designated doctor shall perform additional testing when necessary to resolve the issue in question. The designated doctor shall also refer an injured employee to other health care providers when the referral is necessary to resolve the issue in question and the designated doctor is not qualified to fully resolve the issue in question. Any additional testing or referral required for the evaluation is not subject to preauthorization requirements nor shall those services be denied retrospectively based on medical necessity, extent of injury, or compensability in accordance with the Labor Code §408.027 and §413.014, Insurance Code Chapter 1305, or Chapters 10, 19, 133, or 134 of this title (relating to Workers' Compensation Health Care Networks, Agents' Licensing, General Medical Provisions, and Benefits-- Guidelines for Medical Services, Charges, and Payments, respectively) but is subject to the requirements of §180.24 of this title (relating to Financial Disclosure)."

The requestor states this FCE was part of a Designated Doctor exam; therefore, per 28 Texas Administrative Code §127.10(c), the respondent's denial of reimbursement based upon a lack of preauthorization is not supported.

2. According to the explanation of benefits, the carrier denied payment for the services in dispute in accordance with a negotiated discount/rate. The "Negotiated/Discount" amount on the submitted explanation of benefits denotes a discount was not taken. The Division finds that documentation does not support that the services were discounted due to a contract; therefore, reimbursement for the services will be reviewed in accordance with applicable Division rules and guidelines.
3. This dispute relates to services with reimbursement subject to the provisions of 28 Texas Administrative Code §134.204.

On the disputed date of service, the requestor billed CPT code 97750-FC.

The American Medical Association (AMA) Current Procedural Terminology (CPT) defines CPT code 97750 as "Physical performance test or measurement (eg, musculoskeletal, functional capacity), with written report, each 15 minutes."

The requestor appended modifier "FC" to code 97750. 28 Texas Administrative Code §134.204(n)(3) states "The following Division Modifiers shall be used by HCPs billing professional medical services for correct coding, reporting, billing, and reimbursement of the procedure codes. (3) FC, Functional Capacity-This modifier shall be added to CPT Code 97750 when a functional capacity evaluation is performed".

28 Texas Administrative Code §134.204(g) states "The following applies to Functional Capacity Evaluations (FCEs). A maximum of three FCEs for each compensable injury shall be billed and reimbursed. FCEs ordered by the Division shall not count toward the three FCEs allowed for each compensable injury. FCEs shall be billed using CPT Code 97750 with modifier "FC." FCEs shall be reimbursed in accordance with §134.203(c)(1)

of this title. Reimbursement shall be for up to a maximum of four hours for the initial test or for a Division ordered test; a maximum of two hours for an interim test; and, a maximum of three hours for the discharge test, unless it is the initial test. Documentation is required.”

The requestor states in the position summary that the disputed FCE was performed by the Designated Doctor. A review of the submitted medical bill indicates that the requestor billed for sixteen units, which equals four hours; therefore, the requestor did not exceed the four hour limit set in 28 Texas Administrative Code §134.204(g) for Division ordered FCEs.

Per 28 Texas Administrative Code §134.204(g) to determine the reimbursement for FCEs the Division refers to 28 Texas Administrative Code §134.203(c)(1)(2).

Per 28 Texas Administrative Code §134.203(c)(1)(2), the following formula is used to calculate the Maximum Allowable Reimbursement (MAR): (DWC Conversion Factor/Medicare Conversion Factor) X Participating Amount = MAR.

The 2013 DWC conversion factor for this service is 55.3.

The Medicare Conversion Factor is 34.023.

Review of Box 32 on the CMS-1500 finds that the services were rendered in zip code 77060 which is located in Houston, Texas; therefore, the Medicare locality is “Houston, Texas.”

The Medicare participating amount for CPT code 97750 is \$33.44.

Using the above formula, the MAR is \$54.35 per unit. The requestor billed for 16 units; therefore, \$54.35 X 16 = \$869.60. The respondent paid \$0.00. The difference between MAR and amount paid is \$869.60; this amount is recommended for additional reimbursement.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is \$869.60.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby **ORDERS** the respondent to remit to the requestor the amount of \$869.60 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

_____ Signature	_____ Medical Fee Dispute Resolution Officer	04/17/2015 _____ Date
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YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, 37 *Texas Register* 3833, **applicable to disputes filed on or after June 1, 2012.**

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.